



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Thomas Hausle, MD

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-15-2742-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

April 27, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "...this request was in response to a \$350.00 reduction \* of the \$850.00 for the Designated Doctor Exam performed on 07/08/2014... we are seeking the balance owed to us."

**Amount in Dispute:** \$350.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "... The health care provider billed 99456-W5-WP for the MMI/IR. Texas Mutual staff denied the MMI/IR portion of the exam requesting a valid code &/or modifier be billed. According to the documentation (DWC-69 and Designated Doctor report) provided by the health care provider the claimant has not reached MMI ... thus the provider billed using an incorrect 'WP' modifier. Per Rule 134.204 (i) and (j) for Designated Doctor exam when MMI has not been reached modifier 'NM' is to be billed...

Given the above, no payment is due."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2014	Designated Doctor Examination (MMI/IR)	\$350.00	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursement of Designated Doctor Examinations.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - CAC-P12 – Workers’ Compensation Jurisdictional Fee Schedule Adjustment.
  - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
  - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
  - 892 – Denied in accordance with DWC rules and/or Medical Fee Guideline including current CPT Code descriptions/instructions.
  - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
  - 724 – No additional payment after a reconsideration of services.

### Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

### Findings

1. Review of the submitted information finds that the unpaid services in dispute are for CPT Code 99456-W5-WP. The insurance carrier denied these services with claim adjustment reason code “CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing,” and “732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.”

28 Texas Administrative Code §134.204 (i)(1) requires that “Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier ‘W5’ is the first modifier to be applied when performed by a designated doctor; (B) Attainment of maximum medical improvement [MMI] shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier ‘W5’ is the first modifier to be applied when performed by a designated doctor.”

28 Texas Administrative Code §134.204 (j)(2) states, “(A) If the examining doctor, other than the treating doctor, **determines MMI has not been reached**, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier ‘NM’ shall be added ... (C) If the examining doctor **determines MMI has been reached and an IR evaluation is performed**, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection” [emphasis added].

Additionally, 28 Texas Administrative Code §134.204 (j)(3) states, “An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” 28 Texas Administrative Code §134.204 (j)(4)(C)(iii) states, “If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier “WP.” Reimbursement shall be 100 percent of the total MAR.”

CPT Code 99456-W5-WP indicates that a designated doctor performed an evaluation of MMI and IR testing of the musculoskeletal body area(s). However, the submitted narrative and Report of Medical Evaluation state that the injured employee had not reached MMI. Therefore, the insurance carrier’s denial reason is supported.

2. Because the insurance carrier’s denial was supported, no further reimbursement is recommended.

### Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	Laurie Garnes	June 4, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

### YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**